

# Weber Human Services' Behavioral Health Home

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## Executive Summary

In 2010, Weber Human Services was awarded a national grant to provide an integrated physical health clinic as part of our services to the behavioral health clientele we were serving. Midtown Community Health Center partnered with us to open this clinic and over 1000 of our clients that are seriously mentally ill have received their primary healthcare in this co-located clinic. But the mere co-location of mental health and physical health services, while effective in engaging this population in their healthcare, did not completely close the gap between mental health services and physical health services. In the 2014 legislative session, Weber Human Services was given \$1.4 million dollars for a 2 year pilot project for implementing a Behavioral Health Home (Health Connections) to close this gap and improve client physical health outcomes.

Over the past 16 months, Health Connections has served 265 clients that are seriously mentally ill and have significant physical health risk factors (diabetes, obesity, high blood pressure, etc.). During this time, we have coordinated with doctors, hospitals, insurance companies and other community partners to closely monitor the physical health of these clients and to make sure they are getting the appropriate health care that their conditions require. With the help of these partners, the outcomes have been astounding. For example, 76% of clients with high blood pressure (systolic) have seen improvement and 58% of clients with diabetes have seen improvement in their Glycated Hemoglobin levels. And this is all in just 16 months time.

We firmly believe that over time these results will continue to improve and longitudinal studies will show outcomes similar to what we are seeing across the country in behavioral health homes. The most significant result they are finding is a reduction in ER utilization. While we have not been able to gain access to any data on these individuals related to their ER utilization pre and post of their participation in Health Connections, we have had numerous anecdotal stories shared with us about the

success of many patients in becoming more prudent users of medical resources. In fact, one particular physician that works with several Health Connections clients has told us how beneficial this program has been for the health and safety of his patients.

We continue to partner with at least 2 ACO's to identify other individuals who may be seriously mentally ill with high physical health utilization rates and may be in need of monitoring through Health Connections. Most recently we have been working with Select Health and the Medicaid restricted clients. We have been able to engage several of these clients in more consistent behavioral healthcare and are now better monitoring their physical healthcare as well.

We are also working on another initiative called Ginger.io. This is an innovative new smartphone program to help Health Connections staff stay connected with the clients and to reach out to them when it matters most. The free software regularly checks on the clients to see how they are feeling and gathers information about their daily activity patterns. The app notifies staff on days when the clients are not doing as well so that they can reach out and provide assistance. This is still in its pilot stage but its effects so far have been lifesaving. Through notifications to staff, we were able to identify a client who was in distress and happened to be having small heart attacks. We were able to connect him with the help he needed before the issue became even more serious.

As we have developed this Behavioral Health Home, we have made sure that with appropriate Medicaid match dollars, we will be able to continue and to expand the reach of this innovative program. The Utah Behavioral Healthcare committee is making its' own request for funding related to the Medicaid Match shortfall, therefore I am not making a request for additional funding to support this pilot program at this time. Basically this is a sustainable Medicaid program in the future, but without the legislature addressing the match shortfall, this program will be in jeopardy at the start of the new fiscal year. We are dependent on finding workable solutions to the shortfalls in Medicaid match for behavioral health but we hope that over time we will be able to truly change the trajectory of the shortened life expectancy of our citizens who suffer from serious mental illness.

### Takeaways!

1. Clients that are seriously mentally ill do not have to needlessly suffer and potentially die from physical health ailments just because their mental illness limits their ability to manage their own healthcare. We can provide them with minimal resources and see huge improvements in their mental and physical health, as demonstrated by our outcomes and other Behavioral Health Homes across the

country. It is probable that we can see cost savings over time but in order to study this, point number two is needed.

2. Weber Human Services feels strongly that access to physical health data become a priority to better determine the effects that partnering efforts (such as this behavioral health home) are having on the costs associated with physical healthcare.
3. With adequate funding to support the Medicaid programs, dollars could be freed up to pay for uninsured lives that would also benefit from the services created in the public system. But without adequate funding and addressing the current match shortfall, the health home we have created over the past two years will need to be cut in FY 2017.

Thank you for funding this pilot program. It is a step in bridging gaps for whole healthcare for individuals.

# Data Analysis

## Clients Served

During the 2014 Legislative session, the Utah State Legislature appropriated \$1,440,800 to support the initiation of Utah's first Behavioral Health Home. The focus of a health home is to improve client access to preventive services, wellness programs, and medical care. Health homes initiated across the country have seen remarkable results in improving clinical outcomes in their clients. As of October 30, 2015 the Behavioral Health Home at Weber Human Services (Health Connections) has enrolled and collected baseline data on 265 clients.

Gender	Number of Clients (N=265)
Female	173
Male	92

## Risk Factor Profiles

The following tables outline the physical health risk factor profiles of the 265 clients at Health Connections.

Risk Factor	Number of Clients at Risk	Percent of Clients at Risk
Systolic Blood Pressure	101	38%
Diastolic Blood Pressure	104	39%
Waist Circumference	215	81%
Glycated Hemoglobin (Diabetes)	139	52%
LDL Cholesterol	62	23%
HDL Cholesterol	100	38%
Triglycerides	120	45%

Number of Risk Factors Per Client	Number of Clients	Percent of Clients
Less than 3 risk factors	92	35%
3 or more risk factors	173	65%

## Outcomes of Clients

Of the 162 clients that have been in services with Health Connections for at least 6 months, follow-up data has been collected on 132 clients, which is an 81% follow-up rate.

The following table demonstrates the successes of Health Connections.

<b>Risk Factor</b>	<b>Number of clients at risk with available follow-up data</b>	<b>Percent of clients that have shown improvement</b>
<b>Systolic Blood Pressure</b>	49	76%
<b>Diastolic Blood Pressure</b>	43	59%
<b>Waist Circumference</b>	94	50%
<b>Glycated Hemoglobin (Diabetes)</b>	86	58%
<b>LDL Cholesterol</b>	23	87%
<b>HDL Cholesterol</b>	40	56%
<b>Triglycerides</b>	40	50%

## Services

Health Connections provides 4 main services to its enrolled clients: evaluation of their coordination needs, nursing services to monitor their physical health risk factors, care coordination services to assist clients in gaining access to prevention, wellness and medical care services, and peer support services. Since July 1, 2014, Health Connections staff have documented the following level of services:

<b>Service Category</b>	<b>Total Number of Hours</b>
<b>Evaluation</b>	311.75
<b>Nursing Services</b>	590
<b>Care Coordination</b>	8085
<b>Peer Support</b>	33.5

## Other Initiatives

Weber Human Services continues to pursue data related to physical health costs savings and reductions in utilization of high cost services for those clients in Health Connections. While we have been unable to gain access to this data from the Utah Department of Health, we are currently working with the health plans of the clients to see if they can help us determine any changes in health care utilization.

# Budget Report

Health Connections July 2014 - October 2015	
Salaries and Benefits (11 FTE's)	\$860,582
Training	\$7,405
Vehicle Expense	\$46,729
Other Costs	\$236,807
Total Cost	\$1,151,523
Contract Reimbursement	\$960,535
Excess Cost over Reimbursment	\$190,988
Annual Cost per Client	\$3,308.97

# Client Stories

1- Our first success story is the wife of another Health Connections client. She was present while her husband's intake was completed and asked about services for herself as she is diabetic. During her intake it was discovered that she was not taking her insulin correctly. She had consistently high blood sugar readings and was instructed by her doctor to increase her insulin every few days until her readings were lowered. Our nurse discovered that the client was missing two shots of her insulin per day. Health Connections was able to arrange for her to get special syringes with larger numbers, as her eyesight has been affected by her diabetes. She is now able to see her dosage easier and is following doctor's orders. Her blood sugars are now within normal ranges at least 75% of the time.

2- Client was receiving case management services prior to working with Health Connections. He was struggling with keeping his home clean, keeping appointments and general health. He is diabetic. He had an infection on his foot which was nearly healed when it became infected again. During his Health Connections intake it was discovered that he was not taking his Lantus (diabetes medication) because he didn't know what "nighttime" meant as he has an erratic sleep schedule. He had not taken this medication for nearly a year and was having consistently high blood sugar readings. Health Connections helped him purchase an alarm clock to remind him each evening to take his Lantus. This is reminding him to take his other medications as well. He reports that already he is noticing a difference in how he feels even after just a few weeks. His foot is beginning to heal again. His blood sugar readings are also becoming more normal.

3- Client has been incredibly enthusiastic to be taking part in Health Connections. She is diabetic. She has done a great job in keeping a daily journal of her meter readings. It was during a Wellness visit that it was discovered that the client's meter readings did not correspond with the meter readings in the Doctor's office. The client's sugars were in fact very high and of great concern. Health Connections helped to get the client a new meter and has made several home visits to help the client learn to use her meter correctly as well as understand her diabetic sliding insulin scale. Client is now able to draw up her insulin correctly for her immediate needs and is seeing her sugars begin to lower.

4- When client started with Health Connections his blood pressure was incredibly high, His primary Care Physician was concerned that he would have a stroke. Unfortunately, client was not following through with his doctor's orders. The Health Connections team was able to help the client monitor his blood pressure and educate him on an appropriate diet to help decrease his blood pressure through decreasing his amount of caffeine and by

eating healthier foods. The client has been able to keep his blood pressure at a normal range and has reduced his risk of having a stroke.

5- Client started to reach her goal of becoming healthier through Health Connections by losing 11 pounds in 2 months. She became more proactive by watching what she eats, cutting out fast food and increasing her vegetable and water intake. She has also begun to take water aerobics at the Marshall White gym. Client can't wait to lose more weight and continue to improve her health.

6- Client was on numerous medications for diabetes. After reviewing her medications with her doctor we found out that she did not need to take all of them. Since taking her off some of the medications, she has felt better, and her A1C levels are the lowest they've ever been in years. She feels Health Connections has prolonged her life and is constantly telling her doctors about how much our program has helped her.

7- Client came to us after a recent nursing home stay due to his blood sugars. Client is 36 years old and has severe type 1 diabetes. His diabetes was not under control for years and years. Since client has been with Health Connections, he was able to get into see an Endocrinologist and a Diabetic nurse. The Care Coordinator has also worked with the facility where he lives to manage his dessert and carbohydrate consumption. We coordinated with his providers and adjustments to his insulin were made. Health Connections also educated the client on healthy nutritious snacks that will help manage his diabetes. Client has shown significant improvement with his diabetes, and is continuing to improve on a weekly basis.

8- Client was referred to Health Connections by a social worker at McKay Dee hospital, due to many hospitalizations recently and suspected abuse and neglect. During her intake, it was discovered she was indeed being neglected. Due to no income, lack of Medicaid and/or Medicare, she endured the neglect. When her blood pressure was checked during the intake, she was rushed to the hospital by a Care Coordinator due to such high readings and the risk of a stroke. While at the Hospital, test were administered and it was found she had heart failure. When she was discharged from the hospital, Health Connections was also able to find her a nursing home placement at no cost to her, while her health improves. At the time of her intake, she also brought her medications and we realized there were 4 different medications in one pill bottle. Due to other health complications, which include poor eye sight, she did not realize she had been mixing her pills and taking them incorrectly. With the help of the Health Connections team, and coordination with our pharmacy, we were able to separate, identify and organize all of her medications for her to take accurately.

# Physician Stories

1- A primary care physician at Tanner Clinic that has several mutual clients has shared with us that Health Connections always takes really good care of the patients and that he knows that they will follow through on recommendations because they have someone to explain it to them after their appointment which is more than he can say about his other patients.

2- I have a client that has a hard time keeping track of and remembering things that happen at her appointments. Her PCP at Porter Family clinic reported in an appointment one time that since she started working with HC he has noticed that she has been better able to manage what is happening pertaining to her health. She has found ways to be more organized and track what happened at appointments. As we have gone to appointments she has made it a goal to review with me what she remembered at the end of the appointment and has even contacted me a few times about follow up appointments. Her PCP stated not only has she been better able to manage what's happening with her health, he's also seen improvements in her health as well because she's been on top of it.

3- One of my clients has a bunch of specialists. A lot of times she gets confused with who said what and what changes have been made pertaining to her care plan. Her PCP at Ogden Clinic has a hard time keeping track of all of her specialists and changes if the client is the one reporting it to him. He told her care coordinator that he was really grateful for all of the help his patient receives from HC because through the coordination done by the care coordinator he is better able to manage her overall health and help her best he can.

4- Midtown Clinic Wellness Provider commented in an appointment one day that the role of care coordinator has made a big difference in the lives of some of the patients she sees. She referenced a specific client that before being a part of health connections never attended appointments and was not taking care of her health at all. She said that she noticed once the client started working with HC she started attending appointments with the help of her care coordinator, and her attitude about her managing her physical health changed. Although she still needs assistance from her care coordinator, the client has since found a renewed desire to manage her physical health.